

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN1005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  10/31/2017
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF ELIZABETHON			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 SPRUCE LANE ELIZABETHON, TN 37643		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments  A Licensure survey and complaint investigations #40516, #42531 and #41819 were completed on 10/31/17 at Signature Healthcare of Elizabethton. No health deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

5899

R2SP11

If continuation sheet 1 of 1